No. 98-536

In The

Supreme Court of the United States

October Term, 1998

TOMMY OLMSTEAD, Commissioner of the Department of Human Resources of the State of Georgia, RONALD C. HOGAN, Superintendent of Georgia Regional Hospital/Atlanta, and EARNESTINE PITTMAN, Executive Director of the Fulton County Regional Board,

Petitioners,

v.

L.C. and E.W., each by JONATHAN ZIMRING as guardian ad litem and next friend,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

REPLY BRIEF

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1. The text of the statute does not support this claim, and the "by reason of such disability" language affirmatively prohibits it. Of all the principles auditioning to govern this claim, the words of Title IIA of the Americans with Disabilities Act provide the most complete and final answer to the question whether Congress has itself compelled, or authorized the Attorney General to compel, the States to provide least restrictive care to their disabled citizens:

> Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, [1] be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or [2] be subjected to discrimination by any such entity.

42 U.S.C. § 12132 (1994) (emphasis added).

After two rounds of briefing, it is hard to discern how this 48-word provision, and the "by reason of" principle that firmly anchors it, could suddenly compel least restrictive treatment of the disabled. Here, for example, the language is being used to bar hospital services offered on a voluntary basis, unless at the same time the State fully funds all demand for another service – a community residential placement. Yet neither by providing voluntary hospital services nor by requiring a person to wait her turn for a community placement does the State "exclude[]" the disabled persons from any services "by reason of" their disability nor "discriminate[]" against the disabled "by reason of" their disability. It is a hallmark of everyday citizenship, not a mark of disability, to be eligible for some benefits when they become available (free housing, for example) and others on demand (police and fire protection). No civil rights statute of which we are aware has ever barred such an approach to allocating limited government benefits, to say nothing of doing so where the forbidden conduct consists only of differential treatment "by reason of" disability.

a. Plaintiffs first argue (Resp. Br. 21) that Title IIA does more than just ensure that the disabled receive the same access to State benefits and services provided to the nondisabled; it also regulates, they say, State services that are

provided solely to the disabled, such as mental health care. True enough, but only in situations not pertinent here. Yes, Title IIA by its terms would prevent the State from offering mental health care to its disabled citizens, then denying such care to an individual by reason of, say, blindness. And, yes, Title IIA would prevent the State from involuntarily confining an individual in a State hospital when medical judgment did not support it. But these limited exceptions only prove the general rule: the State does not discriminate "by reason of" disability when it allocates mental health services to its handicapped population in a facially neutral, voluntary, and even-handed way, which is all that happened here.

b. Plaintiffs and their amici next argue (Resp. Br. 16, 17, 21-22; APA Br. 12-14) that the provision bars States not just from excluding the disabled from specific programs or services but also bars discrimination by the government "in its overall provision of services." This apparently is taken to mean (Resp. Br. 17) that Title IIA "ban[s] public entities from requiring unnecessary segregation from the community as the price for receiving needed disability services" because such removal from the community is segregative and limits the individual's access to other government benefits and services, e.g., parks and other public common areas. This argument, however, blurs the distinction between voluntary and involuntary treatment, and also falsely assumes that the hospital itself does not provide a continuum of more and less restrictive care.

As to involuntary treatment, the State may not confine individuals in a hospital against their will unless their illness causes dangerousness or inability to care for themselves. This would be illegal under State law, the United States Constitution, and presumably the ADA. Such treatment would seem to implicate both ADA restrictions – "exclus[ion] from participation in . . . services . . . of a public entity" and "discrimination by such entity" – and would seem to do so "by reason of" disability. But that is not what happened here. As to L.C.'s and E.W.'s actual treatment history, plaintiffs take great liberties with the record, and blur the distinction between voluntary and involuntary treatment. A more extensive response

regarding the treatment that was provided is included in a later section of the brief. See *infra* at 18. But at this point it suffices to say that there is no dispute regarding the validity of their involuntary treatment under the ADA.

Voluntary treatment, by contrast, occurs once the patients consent to hospital treatment. At that point, they "carr[y] the key to the hospital's exit in [their] hand[s]" and must be permitted to leave if they are no longer at risk to themselves or others. *Doe v. Public Health Trust of Dade County*, 696 F.2d 901, 903 (11th Cir. 1983). Still, plaintiffs argue that after they became voluntary patients, the State had an obligation not just to offer to release them and to offer what are referred to as "day" services (e.g., medication and other medical care, counseling, vocational training), but as well to provide plaintiffs with another place to live that was closely supervised and monitored 24 hours a day. Like all disabled individuals, and all citizens generally when it comes to finite government services, however, plaintiffs were asked to wait their turn. Title IIA does not plausibly cover this everyday allocation of finite State resources. The State on this record is by no means forcing anyone to be "segregated," and it is exceedingly misleading to suggest otherwise. Unless the ADA bars the creation of State hospitals for the disabled in the first instance, which plaintiffs concede it does not (Resp. Br. 14), the provision of an optional hospital bed to those without a supervised home in no way "exclude[s]" the handicapped from government services or "discriminat[es]" against them "by reason of" their disability. Further, if Georgia "presumptive[ly]" (APA Br. 11) violates the ADA by not providing a highly supervised residential house as opposed to a hospital bed on demand, then surely it presumptively violates the ADA not to treat all such patients in the community or at a minimum violates the ADA not to create a community-care program in the first instance. The greater authority to decide to create a community-care program in the first instance, in short, includes the lesser authority to determine how many beds it should have.

2. The Attorney General's authority to promulgate regulations "consistent with" other regulations "applicable to recipients of Federal financial assistance" under the Rehabilitation Act of 1973 does not support this claim. Instead of finding textual support for their claim in the most logical place to put such a far-reaching requirement – within the provision that contains the "Discrimination" ban, 42 U.S.C. § 12132 (1994) – plaintiffs and their amici look principally (Resp. Br. 18-19, U.S. Br. 14-15) to another provision entitled "Regulations," 42 U.S.C. § 12134 (1994). That provision says that any regulations "shall be consistent with . . . the coordination regulations . . . applicable to recipients of Federal financial assistance" under the Rehabilitation Act of 1973. 42 U.S.C. § 12134(b) (1994). Through this language, plaintiffs claim (Br. 20), Congress "commanded" *in the statute* that the regulations issued under the Rehabilitation Act would become law under the ADA and, in doing so, Congress thereby mandated least restrictive care.

This argument fails, however, because the prior regulations never received a least restrictive treatment interpretation. To the extent the directive to promulgate regulations "consistent with" those passed under § 504 of the Rehabilitation Act creates any inference at all, in other words, plaintiffs have picked precisely the wrong one. A mandate to enact regulations "consistent with" pre-existing rules is a mandate to stick by those rules and the agency's interpretation of them, which conspicuously did not cover least restrictive care.

The federal government ultimately concedes the core premise of this reading. Even though the Rehabilitation Act was enacted in 1973, the government acknowledges (Br. 10) that it was not until more than 20 years later, in a 1994 amicus brief filed in *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), *cert. denied*, 516 U.S. 813 (1995), that the government first publicly articulated today's interpretation of the integration regulation. That was four years after the ADA was passed and thirteen years after the Court rejected a virtually identical effort to impose least restrictive care on the States under the Developmentally Disabled Assistance Act, see *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981), a

litigation exercise that can only be described as pointless if § 504 throughout that period of time covered precisely the type of mental-health care that the Court rejected in *Pennhurst*.

That leaves a related, but no less important, question. If the "integration" regulation did not require least restrictive care before 1994, what did it require? Consistent with the language of the statute it implemented, the integration regulation focused just on providing equal access to federally-funded government services. As shown below, all agency interpretations confirm this point and none made the regulations applicable to least restrictive care. See *infra*, at 14.

Quite apart from these problems, the single case cited for this theory of "incorporation" of existing regulations (Resp. Br. 20), see *United States v. Board of Comm'rs of Sheffield, Alabama*, 435 U.S. 110, 134 (1978), does not remotely extend to this setting. In *Sheffield*, unlike in this case, the Attorney General had "unambiguously" interpreted the statute in question and had reported his construction to Congress through testimony and exhibits. *Id.* at 131-135, nn.19-22.

3. The Attorney General's authority to promulgate regulations "consistent with this chapter" does not support this claim. Still less tenable is the related argument (Resp. Br. 23, U.S. Br. 14-15) that Congress authorized a least restrictive care regulation when it said that any regulations "shall be consistent with this chapter," 42 U.S.C. § 12134(b), which is to say consistent with Titles I and III of the ADA and the regulations promulgated under them. Had Congress wished to establish this benchmark of liability in Title II, however, it is implausible to think that it would have used language in Title I or Title III to do so. See *Russello v. United States*, 464 U.S. 16, 23 (1983).

Conspicuously missing from the responsive briefs, moreover, is any rejoinder to our opening contention (Pet. Br. 14-15, 34) that Congress knew how to use language regarding "least restrictive care," and yet did not do so here. *See, e.g.*, Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000, et seq. (1994 & Supp. II 1996) ("least restrictive treatment" is a statutory goal for the

States); Individuals with Disability Education Act, 20 U.S.C. §§ 1400 et seq. (1994 & Supp. II 1996) (a free "appropriate" education is required of the States). Congress's decision in Title IIA of the ADA *not* to use language that has imposed such affirmative goals or requirements before and, more, to use language that contradicts these requirements – the "by reason of" limitation – deserves far more respect than plaintiffs have given it.

4. The general language of Title IIA cannot implicitly repeal or displace the vastly more specific provisions of the Medicaid Act. Plaintiffs do not dispute that the Medicaid laws, 42 U.S.C. §§ 1396 *et seq.* (1994 & Supp. II 1996) express a policy preference for treatment in institutions over treatment in the community. They simply point out (Resp. Br. 3, 32; U.S. Br. 25-26) that the law was amended to "permit" states to secure community-based care through special "waiver" programs. This response, however, does not come to grips with the fact that the Medicaid Act addresses in excruciating detail the issues involved in determining when institutional care should or should not be provided, and in determining when community care should or should not be provided. The Act thus favors, allocates billions of dollars for, and highly regulates institutional care. By contrast, Congress more recently has merely *allowed* states to shift toward alternative non-institutional care through its waiver programs. House Comm. on Energy and Commerce, 103d Cong., 1st Sess., Medicaid Source Book: Background Data and Analysis 542 (Comm. Print 1993). The waiver programs are optional for the states, unlike, for example, institutional nursing home services which are mandatory, 42 U.S.C. §§ 1396a(a)(10)(A) (1994 & Supp. II 1996), and community care is specifically limited by the number of "waiver slots" made available, unlike institutional services for the mentally disabled which must be made available on demand. 42 U.S.C. § 1396a(a)(8) (1994 & Supp. II 1996); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998). The complex framework of the Medicaid Act, therefore, contemplates two appropriate and necessary options for treatment of developmentally disabled persons needing the same level of care – the one on demand for

eligible individuals (institutional treatment) and the other only when specifically approved and only according to a limited supply (community treatment). The DOJ's interpretation of the general language of Title IIA and the integration regulation in the end would suddenly convert these waiver programs from limited, optional programs to unlimited mandatory ones, all without any evidence of a meaningful public debate on this point either in Congress or in the Department of Justice.

5. The Congressional findings in the ADA, 42 U.S.C. § 12101, do not support a "least restrictive care" reading of Title II. The final textually rooted argument raised by plaintiffs and their amici (Resp. Br. 17-18, U.S. Br. 12) is that several congressional findings, situated in the preamble to the ADA, support their position. These highly generalized statements, however, do not mandate or by themselves authorize "least restrictive care" regulations. They simply support the notion that States may not involuntarily "segregate" the handicapped by excluding them from public services and benefits provided to the nonhandicapped. Nor may these admirable, but still hortatory, sentiments contradict the text's "by reason of" disability requirement. *National Organization of Women, Inc. v. Scheidler*, 510 U.S. 249, 260 (1994); cf. *Pennhurst, supra*.

6. Title IIA of the ADA and § 504 of the Rehabilitation Act must be read to contain the same rule regarding least restrictive care. In responding to the State's contention that the meaning of Title IIA can be gleaned from § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) (1994), plaintiffs and their amici contend that the meaning of § 504 was not settled by 1990 and therefore that the ADA may still be construed to impose a least restrictive care requirement. But this argument presupposes, correctly in our view, that the two nearly-identical provisions must be given the same reading, either to the effect that they both require least restrictive care or that they both do not. It would suspend customary assumptions about the passage and implementation of legislation to believe that language first enacted in 1973 has just now been found to authorize such a requirement.

In the alternative, plaintiffs elsewhere suggest (Br. 42-43) that the ADA may go further on this issue than § 504 of the Rehabilitation Act does. That approach, however, creates more problems than it solves. The notion that one of these statutes authorizes a least restrictive treatment requirement, while the other does not, asks a lot of the modest differences between the two laws (i.e., the removal of the word "solely" in the ADA, the general findings of congressional purpose added to the ADA, and the admonition to make the ADA regulations "consistent with" their Rehabilitation Act counterparts). This contention also awkwardly suggests that Congress chose to impose a greater regulatory and fiscal burden on the States in a statute enacted without regard to whether federal funding was involved (the ADA) than in a statute enacted only to apply to those receiving federal funding (the Rehabilitation Act). That gets the customary assumptions about congressional regulation of the States exactly backwards.

7. The triggering event of *Chevron* deference – an ambiguous statute – comes after, not before, all interpretive canons have been exhausted to ascertain the meaning of a law. Plaintiffs and their amici place most of their eggs in the *Chevron*-deference basket, arguing not that Title IIA of the ADA requires least restrictive care, but that sufficient ambiguity clouds the question so that the Department of Justice was entitled to pass regulations to that effect. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). But, in doing so, they skip an important step. The conclusion that a statute is ambiguous, thereby triggering *Chevron* deference, comes at the end, not the beginning, of the quest for meaning and most importantly after all interpretive tools have been used. *Id.* at 843, 845-853.

a. *Chevron*, to start with, does not allow an executive agency to disregard the text of a statute. As shown, the language of Title IIA is utterly inconsistent with the least restrictive care mandate that the Attorney General has proposed.

b. *Chevron* also bars an agency from overriding relevant interpretations of a statute previously issued by this Court. *Lechmere, Inc. v. NLRB*, 502 U.S. 527, 536 (1992). Whatever else the Department of Justice may do regarding interpretations of § 504 or Title IIA, then, its interpretations may not disregard the Court's.

Except briefly to describe the litigation positions in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), *Alexander v. Choate*, 469 U.S. 287 (1985), and *Traynor v. Turnage*, 485 U.S. 535 (1988), and to ignore *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986), altogether, plaintiffs and their amici offer no meaningful response to these prior interpretations of § 504 and the inconsistency between those limiting decisions and the expansive regulation they are advancing. *Davis, Choate* and *Bowen* cannot coexist with a requirement presumptively to subsidize every nursing-home and mental-health patient's request for a supervised residential bed, as opposed to an institutional bed. And surely if the State need not extend a benefit to all categories of handicapped persons under § 504 (*Traynor*), it may choose to allocate a limited supply of one government benefit (e.g., residential housing) to an entire category of handicapped individuals on a first-come-first-served basis.

c. Nor does *Chevron* allow plaintiffs and their amici to sidestep the plain statement rule. The clear statutory language that this canon requires precludes the ambiguity-prompted regulation that the Department of Justice has innovated. Whether in the area of Spending Clause legislation like the Developmentally Disabled Assistance Act at stake in *Pennhurst*, or legislation designed to abrogate a State's Eleventh Amendment immunity like the legislation at stake in *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985), or legislation that affects traditional areas of State sovereignty like the age discrimination laws at stake in *Gregory v. Ashcroft*, 501 U.S. 452 (1991), or (we submit as well) legislation under § 5 of the Fourteenth Amendment that is premised on prior or threatened constitutional violations, the Court will not lightly infer congressional intrusion into these sovereignty-sensitive subjects. See *id.* at 468-70.

Even the most aggressive interpretation of *Chevron* cannot overcome this doctrine. Otherwise, the statutory ambiguity in the DDA at issue in *Pennhurst* would have allowed the applicable federal agency, or as here the Department of Justice, to promulgate a regulation requiring least restrictive care; the statutory ambiguity in *Atascadero* would have allowed the applicable agency to pass a regulation exposing the States to money damages; and the statutory ambiguity in the federal age discrimination law at issue in *Gregory* would have allowed an executive-branch agency to make the law applicable to State judges. To state the problem this way, it seems to us, is to answer it. *Chevron* does not trump this time-respected canon, converting a requirement of clear statement into one of clear silence. Nor, as we have shown (Pet. 43-44) and as plaintiffs and the federal government have yet to respond, would this application of *Chevron* be consistent with *Garcia v. San Antonio Metropolitan Transit Auth.*, 469 U.S. 528, 550-54 (1985).

At least two of these applications of the clear-statement rule are pertinent here, even though just one of them would suffice to reverse the Eleventh Circuit's decision. In the first place, Title IIA has a Spending Clause lineage. Patterned after § 504 of the Rehabilitation Act (which applies only to "recipients of federal funding") and worded in all pertinent respects just like it, Title IIA must be construed similarly to this Spending Clause legislation. *See Atascadero*, 473 U.S. at 246-47 & n.5 (assuming for the sake of argument that § 504 constitutes Spending Clause legislation). Neither § 504 nor Title IIA can meet the *Pennhurst* clear-statement hurdle.

A clear statement is also required because the Court will not infer such a sudden intrusion into traditional local authority unless clearly stated. *See Gregory. Pennhurst*, once again, points the way, because it indicates that deinstitutionalization would lead to "massive" changes at the local level. 451 U.S. at 24. For this reason, *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725, 732 n.5 (1995), a case dealing merely with zoning restrictions under the Fair Housing Act, is simply inapposite. Even under the test of *City of Edmonds*, moreover, federal direction as to how States should treat those who

cannot care for themselves and a directive that they do so in the least restrictive setting would lead not just to massive changes at the local level but would clearly implicate "a decision of the most fundamental sort." *Id.*

8. Plaintiffs offer no meaningful response to the contention that the path followed in *Pennhurst* is the path that ought to be followed here. Two basic responses are offered to the view that *Pennhurst* supplies dispositive guidance here. Plaintiffs argue (Br. 45) that the law at issue in *Pennhurst* involved Spending Clause legislation while the ADA does not. But this view assumes that § 504 of the Rehabilitation Act, which appears to be Spending Clause legislation, *see Atascadero*, and Title IIA of the ADA, which is not, should receive different interpretations. That disregards precedent from this Court, to say nothing of the overriding principle of common sense, that two provisions given the same words should be given the same interpretation. The federal government has not joined in this argument.

What the federal government does say (Br. 28-29), however, does no better. It contends that *Pennhurst* is inapplicable because the DDA said that treatment "*should* be provided in the setting that is least restrictive of the person's personal liberty," while the ADA says that "no qualified individual with a disability *shall*, by reason of such disability . . . be subject to discrimination." Yet when one statute says something specifically "should" be done ("least restrictive care") and another says something generally "shall" not be done ("discrimination"), neither law supplies a clear statement regarding least restrictive care. This argument also overlooks other language in the *Pennhurst* statute, which said that "[p]ersons with developmental disabilities have a right to appropriate treatment," and that the States "have an obligation" to provide care that is "appropriate to the needs of such persons." 451 U.S. at 13 (quoting 42 U.S.C. § 6010). Surely a decision that this language does not compel least restrictive or the most appropriate care compels a like conclusion under the far less specific terminology of Title IIA of the ADA.

9. The legislative history does not support a "least restrictive care" interpretation. Plaintiffs devote large sections of their brief (*e.g.*, Br. 25-32) to the proposition that the legislative history supports their interpretation. The long and the short of it, however, is that even this exhaustive search has not located a single discussion regarding the complex issue of how, when and whether mental health care needs must be provided in a community as opposed to a hospital setting. Only a most reckless legislature would take on the multifaceted subject of deinstitutionalization, then establish an across-the-board value judgment about it, all without any testimony from those in the field, without any consideration of the appropriate number of State hospital beds that must remain in the States, without any consideration of how this new requirement would be paid for (particularly when it comes to purchasing the types of residential homes plaintiffs have requested), without any discussion of how this new requirement would interrelate with Medicaid funding and requirements, and most essentially without any discussion of the risks of unduly rapid deinstitutionalization. No party has identified any meaningful discussion in the hearings, committee reports or floor debates regarding the alleged requirement that residential housing be presumptively supplied on demand to those who no longer must be involuntarily committed to a State hospital. The same deficiency undermined the effort to broaden § 504 in *Choate*. Yet, there, "nothing in the pre- or post-1973 legislative discussion of section 504," the Court reasoned, "suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid." 469 U.S. at 307. A like conclusion applies here.

To the extent legislative history has any bearing on this subject, moreover, it may be used only to resolve statutory ambiguities, not to establish a "clear statement" of legislative meaning. *Atascadero*, 473 U.S. at 242. The virtual concession that ambiguity clouds this question of statutory interpretation,

in other words, is fatal to this contention. Under no circumstance may legislative history supply a clear statement that Congress failed to supply in the text.

10. Even if *Chevron* otherwise applies here, the Department of Justice's regulation, and the agency's new interpretation of it, do not deserve deference. In response to the State's argument that the Department's new interpretation is not entitled to deference because it has been inconsistent, plaintiffs (Br. 39-41) and the Department (Br. 25) both claim that various briefs filed by the United States in *Pennhurst* represent a consistent interpretation. The Department states that it argued in *Pennhurst* that "in certain circumstances, Section 504 prohibits unnecessary institutionalization. . . . " Br. 25. But the government cannot hide its interpretive reversal under these overly broad generalizations encompassing vastly different interpretations. The government makes a partial concession here that its prior position was that, under *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), "a State could not be required to create a new system of community facilities where none existed before." *Id.*, citing U.S. Br. at 29, *Halderman v. Pennhurst State Sch. & Hosp.*, No. 78-1490 (filed Oct. 14, 1981). In fact, the government conceded more in its 1981 brief: "The issue here is not whether Section 504 would require Pennsylvania to create or expand a system of community facilities. Nor does the United States urge any such interpretation of the statute." U.S. Brief at 27, *Halderman v. Pennhurst State Sch. & Hosp.*, No. 78-1490 (filed Oct. 14, 1981). That interpretation would have precluded the adverse decision here, since there were no available places in Georgia's existing program before the plaintiffs' placements were provided.

In the final analysis, the government has not been able to point to any interpretive material supporting their current expansive interpretation. And in the most logical places to find such statements, deinstitutionalization was not mentioned at all: (1) the Department of Health, Education and Welfare's original regulations, 45 CFR Part 84.4(b)(2), 42 Fed. Reg. 22676, 22679 (5-4-77); (2) HEW's coordination regulations,

45 CFR Part 85, 43 Fed. Reg. 2132 (1-13-78); (3) the Department of Justice's Final Rule, 28 CFR Part 35; (4) DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, FINAL REGULATORY IMPACT ANALYSIS OF THE DEPARTMENT OF JUSTICE REGULATION IMPLEMENTING SUBTITLE A OF TITLE II OF THE ADA, 12-18-91); or (5) DEPARTMENT OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT, TITLE II TECHNICAL MANUAL, COVERING STATE AND LOCAL GOVERNMENT PROGRAMS AND SERVICES, 1993 EDITION (1994 Supp.). Most notably, the Regulatory Impact Analysis of Title IIA, which was prepared by the Justice Department itself, concluded the law would not have a significant impact. The report states that "it seems relatively clear that its overall economic impacts are likely to be quite minor. Title IIA essentially operates to extend the 'program accessibility' standards of the Rehabilitation Act of 1973 to the last small remaining portion of the public sector not yet covered by those standards." *Id.* at 4. The report concluded by stating that "Subtitle A of title II, therefore, should be regarded as being at most a minor extension of the Rehabilitation Act standards to the last remaining portion of the public sector." *Id.* at 22. Finally, "[t]he litigation expenses attributable to subtitle A title II are likely to be minimal, given that it imposes only the *now-familiar* standards of the Rehabilitation Act upon a group of entities knowledgeable about its requirements." *Id.* at 24 (emphasis added). No State was "familiar" with such a deinstitutionalization mandate before 1990, and none had reason to expect one after 1990.

11. The Eleventh Circuit's ruling itself constitutes a fundamental alteration of Georgia's programs for providing health care to the mentally disabled. Much is made in the opposition briefs of the "fundamental alteration" defense the State may assert on remand. But, in pushing the availability of this defense and in trying to craft an argument that offers all things to all people, plaintiffs make at least three mistakes.

First, plaintiffs and their amici incorrectly suggest that institutional treatment is generally "unnecessary" and thus constitutes discrimination in almost every circumstance, a position to which the Eleventh Circuit subscribed. If "at a given time the patients could be treated in the community" by

being provided whatever level of care they need regardless of cost, the court held, then institutional treatment presumptively constitutes discrimination. Pet. 22a-23a. But since virtually anyone "can" be treated in the community given unlimited funds (J.A. 138), this analysis approaches, if not reaches, the conclusion that institutional treatment is *per se* discrimination. By limiting considerations of cost only to the expenses of these two individuals as opposed to all individuals who might want such care, moreover, the court of appeals, and now plaintiffs, have completely foreclosed any meaningful defense. Pet. 29a. Not surprisingly, the district court on remand has already refused to admit the State's evidence concerning the system-wide impact of providing community placements under these circumstances, and already rejected the State's fundamental alteration defense. 1/29/99 Order.

Second, and relatedly, the federal government's (Br. 18-19) and the Eleventh Circuit's formulation (Pet. 22a-24a) of "deference to medical judgment" misapplies and undermines this important standard. The traditional purpose of deferring to medical judgment concerning State hospital care is to minimize "interference by the federal judiciary with the internal operations of the institutions," and to give deference to the presumptively valid decisions of expert administrators and medical professionals. *Youngberg v. Romeo*, 457 U.S. 307, 322 and n.29 (1982). But, in the Eleventh Circuit's and the government's view, professionals determine only if a patient "could" be placed in the community regardless of cost and other administrative considerations, an approach that will virtually always make hospitalization "unnecessary" and will virtually always insert the judiciary and DOJ into State placement decisions and ultimately the State's planning and budgeting process.

Finally, DOJ's new recognition of the impact of its reinterpretation of the integration regulation (Br. 25) underscores the fact that the interpretation itself requires a fundamental alteration of the State's system by requiring the closing of hospitals, increased transitional costs, full funding of the

existing demand for community placement for eligible individuals (estimated to cost $100 million in State and federal funds to serve 1,900 persons on the waiting list, J.A. 202) plus funding of an *indeterminate amount* of increased demand. Br. 21, 26. Although the government's new interpretation of the defense indeed allows a more thorough consideration of these impacts, it is hard to imagine how a litigation-driven standard that requires such changes is not a fundamental alteration of Georgia's system and potentially the health care systems of every other State. J.A. 201.

12. The lower-court litigation history of § 504 does not support a least restrictive care interpretation of Title IIA. Plaintiffs concede that the Third and Seventh Circuits rejected a "least restrictive treatment" interpretation of § 504 prior to the enactment of the ADA. See *Clark v. Cohen*, 794 F.2d 79 (3rd Cir. 1985), *cert. denied*, 479 U.S. 962 (1986); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). And the United States' reference to the merest of dicta in *Kentucky Ass'n for Retarded Citizens, Inc. v. Conn*, 674 F.2d 582, 585 (6th Cir.) ("assuming arguendo" that § 504 could be interpreted to require treatment in the "least restrictive alternative"), *cert. denied*, 459 U.S. 1041 (1982), is not to the contrary. The other appellate decision announced in 1990, though admittedly shortly after the ADA was passed, nonetheless confirms the uniformity of the courts of appeals' decisions interpreting the Rehabilitation Act. *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990). See also *Jackson v. Fort Stanton Hosp. & Training Sch.*, 964 F.2d 980 (10th Cir. 1992).

13. Plaintiffs' rendition of the facts is misleading. In this case, which was decided on summary judgment against the State by the Eleventh Circuit, plaintiffs inexplicably insert a lengthy and misleading set of facts. In response, we simply note the following undisputed facts as to L.C. (which are representative of both patients' treatment history) by way of providing a more complete context for this decision.

a. The State tried repeatedly to provide community-based care to L.C. before her most recent admission to GRH-A, the State hospital. Unfortunately, "[c]ommunity placement

failed over and over due to her threatening and violent behavior." R59, Ex. 13 at 2. On her most recent admission, L.C. was sent to GRH-A for evaluation after she threatened her community job supervisor with a knife. R59, Ex. 44 at 1. The job had been provided to her as an additional support while she lived in a community residential placement, an apartment with a full-time, one-on-one, live-in staff. R59, Ex. 13 at 4, 5. By the time the knife incident occurred, L.C. had lived there for not quite a year, and the May 1992 admission was her fifth emergency hospitalization during that time. *Id.*; R60, Amin dep. 87. After that admission, the community-placement provider notified the institution that it would not accept L.C. again. R59, Ex. 28 at 1.

b. Some of L.C.'s psychotic symptoms such as hallucinations were controlled early in this hospitalization. R60, Amin dep. 52; R60, Patel dep. 97-99. That rapid progress, however, was not matched by improvement in her disability-based behavior, which continued to be far from stable. R60, Amin dep. 84-85. She continued at times to fight and attack others without provocation, become verbally and physically intrusive during conversations with staff and other patients, scream, and urinate and disrobe inappropriately. R2, Exs. B ¶13, E-6 to E-8; R59, Ex. 13 at 2; R60, Amin dep. 49-50. Each of L.C.'s two successive treating psychiatrists concluded, based on her treatment history, that this aspect of her disability required improvement before community placement could be attempted again; otherwise they would simply be "setting her up for failure." R60, Amin dep. 63, 107; R59, Ex. 44 at 2; R60, Patel dep. 76-77, 88. This improvement did occur with treatment but not until April or May 1995, just before her trial release and subsequent discharge. R60, Amin dep. 58-59; R60, Patel dep. 88, 91-92, 97-99; R61, Ex. A ¶5.

c. As L.C.'s condition improved, she could and at various times did in fact leave the hospital and receive a wide variety of community-care services while at times living outside the hospital and while at other times living at the hospital and leaving it during the day. She began to leave the institution in August 1994, via public transportation for persons with disabilities, to attend a daily community-based

program that included social activities, vocational opportunities, and field trips; L.C. returned on the bus each evening to the institution. R2, Ex. F.

d. It became clear over time that, because of L.C.'s chronic and serious disabilities, a community placement for her would have to offer an unusually high level of support, including 24-hour supervision, medication monitoring, assistance with activities of daily living, structured day activities, and vocational-rehabilitation, mental-health, and mental-retardation services. R59, Ex. 13; R60, Amin dep. 61, 69-70; R60, Patel dep. 101. At the specific time that she first became ready for placement, all of Georgia's matching funds for Medicaid waivers were already being used to provide community placements for other disabled persons. *See* J.A. 135-140. Consequently, GRH-A in May 1995 arranged an extended monitored trial visit by L.C. to her mother's home. Later, in February 1996, when funds became available, L.C. was placed in a highly structured community placement. Pet. 2a, n.2.

14. Plaintiffs' policy-based arguments are inaccurate and unpersuasive. In light of plaintiffs' inflammatory references to eugenics, racial segregation and other inapt charges, it asks too much of Georgia not to respond. Because such unfair generalizations have "wounding stigmas" of their own, let us say the following.

First, since 1978, separate and apart from the Medicaid waiver program, Georgia on its own initiative has required the "least restrictive alternative placement" within the limits of funds appropriated for such care. O.C.G.A. §§ 37-3-161, 37-3-1(10) (1995). Between 1992 and 1997, the number of persons funded in Medicaid waiver community placements in Georgia increased from 283 to 1,938 (significantly more than the 700 that the Department identified, U.S. Br. 21); 500 State hospital beds were eliminated system-wide and two large State institutions were closed (significantly more than the 237 beds that the plaintiffs identified, Br. 5); hospital admissions declined 30 percent; patient-days of hospital care declined 19 percent; and the percentage of community funding increased

from 51 percent to 57 percent of the combined community and institutional funding. J.A. 199-201.

Nor is it appropriate to suggest that Georgia should simply purchase more of these community residences, which plaintiffs claim are less expensive than providing care in a hospital, so that all of its disabled citizens may live in publicly funded residences rather than in State-run hospitals. As the federal government itself has recognized, when a State begins offering a residence with 24-hour supervision to individuals in need of psychiatric care at no extra cost to the individual, the demand for this benefit will predictably increase. U.S. Br. 21; GENERAL ACCOUNTING OFFICE/HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, SUCCESSFUL STATE EFFORTS TO EXPAND HOME SERVICES WHILE LIMITING COSTS 4 (Aug. 1994). This expanded demand makes it difficult simply to assume that, all things being equal, an unlimited supply of hospital-based care will cost less than an unlimited supply of community-care residences. *Id.*

As the facts of this case well illustrate, moreover, a State must frequently ensure that it has available both hospital-care beds and community-based-care beds for the same individual. Both plaintiffs in this case have historically been in and out of State hospitals on an involuntary basis, and there can be no assurance that even the best community-based care will guarantee that the State will never need involuntarily to commit such an individual again. Moving an individual into a community-based program, in short, does not mean that the State no longer needs to have available a hospital bed in the event they need such care in the future. For this reason, States face

serious risks with erring on the side of providing too few rather than too many State hospital beds.

Respectfully submitted,

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